	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 A. BUILDING 01 B. WING			(X3) DATE S COMPLI 10/13/2	ETED		
		100000	D. 111	_	DDDEGG GITTY GT ATTE TID GODE	10/13/	2015
NAME OF P	ROVIDER OR SUPPLIER			353 TYL	ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER			IN 46402		
(X4) ID		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
K 0000		,,					
DI 1 04							
Bldg. 01	A Life Safety Co	ode Recertification and	K 0	000			
	State Licensure S	Survey was conducted by					
	the Indiana State	Department of Health in					
	accordance with	42 CFR 483.70(a).					
	Survey Date: 10	/13/15					
	Facility Number:	: 000369					
	Provider Number						
	AIM Number: 1	00275190					
	At this Life Safe	ty Code survey, South					
	Shore Health & 1	Rehabilitation was found					
	not in complianc	e with Requirements for					
	Participation in N	Medicare/Medicaid, 42					
	CFR Subpart 483	3.70(a), Life Safety from					
	Fire and the 2000	0 edition of the National					
	Fire Protection A	Association (NFPA) 101,					
	Life Safety Code	e (LSC), Chapter 19,					
	Existing Health (Care Occupancies and					
	410 IAC 16.2.						
	This one story fa	cility with a partial					
	basement was de	etermined to be of Type II					
	(222) construction	on and was fully					
	sprinklered. The	e facility has a fire alarm					
	system with smo	ke detection on all levels					
	including the cor	ridors, areas open to the					
	corridors, and ba	ttery operated smoke					
	detectors in the r	esident sleeping rooms.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/13/2015
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0021 SS=E Bldg. 01	census of 63 at the All areas where the customary access areas providing from the back used. Quality Review of DA. NFPA 101 LIFE SAFETY CO. Any door in an exicenclosure, horizon hazardous area end by devices arrange all such doors by a facility upon activation at the required material such doors in the passing through the required smoke designed and the required smoke designed. 19.2.2. Based on observing facility failed to doors, a hazardow with self closer aframe. This deficit	t passageway, stairway tatal exit, smoke barrier or inclosure is held open only ed to automatically close zone or throughout the ation of: anual fire alarm system; tectors designed to detect rough the opening or a etection system; and prinkler system, if 2.6, 7.2.1.8.2 ation and interview, the ensure 2 of 2 Kitchen as area, was provided and would latch into the etent practice could affect dents using the Large	K 0021	This Plan of Correction constitutes my written allegation of compliance for the deficiencited. However, submission of this Plan of Correction is not admission that a deficiency export that one was cited correctly. This Plan of correction is submitted to meet requirement established by state and federlaw. Corrective	cies f an xists /.

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	of Correction identification number: 155530	A. BUILDING B. WING	01	COMPLETED 10/13/2015
	PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	353 TYI	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Based on observation with the Maintenance Manager on 10/13/15 at 12:47 p.m., one of the Kitchen doors was propped open with a door stop. Another Kitchen door was open because the bottom of the door was catching on the floor. Based on interview at the time of each observation, the Maintenance Manager acknowledged the aforementioned conditions. 3.1-19(b)		actionsaccomplished for the residents found to be affected by the alleged deficientpractice: The doorstop was removed for 1 of 2 kitchen door and 2 of 2 kitchen door was repairedso a not to catch on the floor and to properly close. Identification of otherresider having the potential to be affected by the same alleged deficientpractice and corrective actions taken All other hazardous area dood the facilityhave been checked ensure proper functioning and that no other door props arepresent. No new issues noted. Measures put in placeand systemic changes made to ensure the alleged deficient practice does notrecur. Kitchen staff have been in-serviced about theimportant of having doors shut and not propped open. Maintenance manager ordesignee will check doors in the facility to ensure proper functioning andthat the are no door props present. How will the corrective actionbe monitored to ensure the deficient practice will no recur? TheMaintenance Manager will conduct rounds weekly to ensure that the all facilitydoors included the kitchen doors are properly closing and not propped	ce c

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Facility ID: 000369

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155530	B. WI	NG		10/13/	2015
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		353 TYL	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					open.Results of weekly audits be reported at monthly QAPI meeting, or untilproblem is considered resolved. Problem will be considered resolved whenno new issues are identif over a two month period.	1	
K 0025 SS=E Bldg. 01	least a one half ho accordance with 8 terminate at an att protected by fire-ra glass panels and s of two separate co on each floor. Dar	e constructed to provide at our fire resistance rating in .3. Smoke barriers may rium wall. Windows are ated glazing or by wired steel frames. A minimum ompartments are provided in of smoke barriers in fully entilating, and air					
	Based on observe facility failed to caused by the particular conduit through walls were protes smoke resistance LSC Section 19. barriers to be conwith LSC Section 8.3.6.1 requires to service materials wire to be protect the penetrating it barrier shall be for capable of maintenance.	ation and interview, the ensure the penetrations ssage of wire and/or 2 of 2 smoke barrier cted to maintain the e of each smoke barrier. 3.7.3 requires smoke astructed in accordance as 8-3. LSC Section the passage of building a such as pipe, cable or sted so the space between them and the smoke silled with a material aining the smoke smoke barrier or be	K 00	025	This Plan of Correction constitutes my written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not a admission that a deficiency exor that one was cited correctly. This Plan of correction is submitted to meet requirement established by state and feder law. Corrective actionsaccomplished for thoresidents found to be affected by the alleged deficient practice. All identified penetrations noted will be seal with 3M Fire Barrier 4Hr rated caulk by 11/12/15. 2. Identification of other	n ists ts al se d	11/12/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	01	COMPL	ETED
		155530	B. W	ING		10/13/	2015
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L		353 TYI			
		REHABILITATION CENTER			IN 46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	protected by an a	approved device designed			residents having the potentia	al	
	for the specific p	ourpose. This deficient			to be affected by the same		
	practice could af	fect staff and up to 36			allegeddeficient practice and		
	residents.	1			corrective actions taken. All		
	Tobladitis.				remaining smokebarriers were inspected for un-sealed	;	
	Piudiuusiud da				penetrations. No findings.		
	Findings include				3. Measures put inplace and		
					systemic changes made to		
	Based on observ	ations with the			ensure the alleged deficient		
	Maintenance Ma	nager on 10/13/15 at			practice doesnot recur. Any		
	1:58 p.m. then as	gain at 2:07 p.m., the			new construction or repairs		
	smoke barrier ne	ear resident room 414			involving wires or pipes		
		g tile was an unsealed			penetratingfirewalls will be sea		
					with 3M Fire Barrier 4Hr rated		
	•	h was a 1 inch by 4 inch			caulk.		
		Additionally, insulation			4. How will thecorrective acti	ion	
	was stuffed into	the smoke barrier. Then			be monitored to ensure the		
	again the smoke	barrier near resident			deficient practice will not		
	room 316 above	the ceiling tile was an			recur? Any new construction orrepair.	0	
	unsealed penetra	tion which was a half of			involving wires or pipes	5	
	•	able wires. Additionally,			penetrating firewalls will be		
		ruffed into the smoke			inspected by theMaintenance		
					Manager, or designee, for		
		n interview at the time of			appropriate fire barrier		
		, the Maintenance			applicationprior to completion	of	
	Manager acknow	vledged each			project.		
	aforementioned	condition.					
	3.1-19(b)						
	(0)						
K 0029	NFPA 101						
SS=E	LIFE SAFETY CO	DE STANDARD					
Bldg. 01		d construction (with ¾					
-		ors) or an approved					
		nguishing system in					
		3.4.1 and/or 19.3.5.4					
	•	s areas. When the					
		tic fire extinguishing sed, the areas are					
	j system option is u	Jou, the areas are	1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETED				ETED
		155530	B. WING 10/13/2015				2015
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L Comment					
COLITIL	CHODE HEALTH &	DELIADII ITATION CENTED			LER ST		
500 IH 8	SHURE HEALTH &	REHABILITATION CENTER		GARY,	IN 46402		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	separated from ot	her spaces by smoke					
	resisting partitions	and doors. Doors are					
	self-closing and no	on-rated or field-applied					
		hat do not exceed 48					
		ottom of the door are					
	permitted. 19.3.						
	Based on observ	ation and interview, the	K 0	029	This Plan of Correction		11/12/2015
	facility failed to	ensure the corridor door			constitutes my written allegation		
	1	Storage room, a			of compliance for the deficient		
		was provided with self			cited. However, submission of		
	· ·	l latch into the frame.			this Plan of Correction is not a admission that a deficiency ex		
					or that one was cited correctly		
	This deficient pr	actice could affect staff			This Plan of correction is	•	
	and 35 residents	using the Large Dining			submitted to meet requiremen	ıts	
	Room.				established by state and feder		
					law. Corrective	· • ·	
	Eindings include				actionsaccomplished for tho	se	
	Findings include	·-			residents found to be affected		
					by the alleged		
	Based on observ	ation with the			deficientpractice. Aself-closir	na	
	Maintenance Ma	nager on 10/13/15 at			mechanism was installed on the	-	
	12:31 p.m., the k	Kitchen storage room			indicated Kitchen storage doo	r.	
	-	ridor which is open to the			Thiswas tested to assure door	r	
	-	_			latches properly. This was		
		om. Inside the Kitchen			completed on 10/16/15.		
		s at least sixty boxes			Identification of otherresider	nts	
	stored on top of	one another. The Kitchen			having the potential to be		
	storage room did	I not positively latch into			affected by the same alleged	I	
	the frame when t	-			deficientpractice and		
		time of observation, the			corrective actions taken. All		
		*			other hazardous area doors h		
		nager acknowledged the			beenchecked to ensure that the		
	aforementioned	condition.			have properly close and positi	•	
					latch. Noother issues identifie	u.	
	3.1-19(b)				Measures put in placeand		
					systemic changes made to ensure the alleged deficient		
					_		
					practice does notrecur. Maintenancemanager or		
					designee will audit doors		
					weekly to ensure proper		

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	OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(x3) date survey COMPLETED 10/13/2015
	PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			functioning. Howwill the corrective action be monitore to ensure the deficient praction willnot recur? Results of weekly audits will be reported at QAPI monthly meetings or uproblem is considered resolved Problemwill be considered resolved when no new issues identified over a two monthper	ntil d. are
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 Large Dining Room exterior exit discharge paths were readily accessible at all times. This deficient practice could affect visitors, staff and at least 35 residents in the Large Dining Room. Findings include: Based on observation with the Maintenance Manager on 10/13/15 at 11:59 a.m., the Large Dining Room exit discharged into a gated area. The gate door had a locked padlock. Based on interview at the time of observation, the Maintenance Manager said only maintenance has a key to the padlock and acknowledged the aforementioned condition.	K 0038	This Plan of Correction constitutes my written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exor that one was cited correctly. This Plan of correction is submitted to meet requirement established by state and feder law. Corrective actions accomplished for tho residents found to be affected by the alleged deficient practice. Keys to the identified Dining Room exit gatedoor have been distributed to all activity staff and nurse supervisors on each shift. This will ensure that if there was an emergency on any shift a staffmember could open the glidentification of other resident having the potential to be	n ists . ts al se d n nd t. as ate.

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/13/2015
	ROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	3.1-19(b)		affected by the same alleged deficientpractice and corrective actions taken. No others identified. Measures put in place andsystemic changes made ensure the alleged deficient practice does not recur MaintenanceManager in-serv the activities staffas well as the nurse supervisors on each shi on how to make sure gate key ison key ring and how to open lock. Maintenance Manager of designee will auditstaff who we assigned gate keys to ensure they have them on theirpersor How will the corrective actionbe monitored to ensure the deficient practice will not recur? MaintenanceManager will be report findings at the monthlyQAPI meeting. This will be on-going.	to iced e fft - ere that i.
K 0044 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and	K 0044	This Plan of Correction constitutes my written allegatic of compliance for the deficience cited. However, submission of this Plan of Correction is not a admission that a deficiency exor that one was cited correctly. This Plan of correction is submitted to meet requirement established by state and feder law. Corrective	n ists .

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/13/2015
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE /LER ST , IN 46402	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	mechanisms shall overcome fire remechanism so the achieved on each deficient practice only the 35 residuarge Dining Roundle Hall is being remembered. Findings include Based on observe Maintenance Ma 12:08 p.m. the finding Room fair Based on intervisions observation, the	sistance of the latch at positive latching is a door operation. These es could affect staff and ents that might be in the from, because the 200 ovated. : ation with the mager on 10/13/15 at re doors near the Large illed to latch when tested.		actionsaccomplished for the residents found to be affected by the alleged deficient practice. The fire doors identified during the survey have been repaired and are closing properly. Identification of other resident having the potential to be affected by the same alleged deficient practice and corrective actions taken. All other fire doors have been checked for proper closing. All found to be working properly. Measures put in place and systemic changes made ensure the alleged deficient practice does not recur. Maintenance Manager or designee will ensure proper functioning of smoke doors dumonthly fire drills which would occurat least twice a month. How will the corrective action be monitored to ensure the deficient practice will no recur? The results of fire drills be reported to the monthly QAPImeeting. This will be on-going.	g nts to e t
K 0045 SS=E Bldg. 01	exit discharge, is a any single lighting the area in darkne emergency lighting section 7.8.) 19	ans of egress, including arranged so that failure of fixture (bulb) will not leave ss. (This does not refer to g in accordance with	K 0045	This Plan of Correction	11/12/2015
	Daseu on observ	ation and interview, the	K 0043	constitutes my written allegati	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	01	COMPL	ETED
		155530	B. Wl	ING		10/13/	2015
	n oxympun o			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L .		353 TYI	LER ST		
		REHABILITATION CENTER			IN 46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility failed to	provide exterior			of compliance for the deficience		
	emergency lighti	ing for 1 of 1 external			cited. However, submission of		
	Large Dining Ro	oom exit. LSC Section			this Plan of Correction is not a		
		emergency lighting for			admission that a deficiency ex or that one was cited correctly		
	•	shall be provided for the			This Plan of correction is	•	
	_	•			submitted to meet requiremen	ts	
		exit discharge. This			established by state and feder		
		e could affect staff and at			law.		
	least 35 in the La	arge Dining Room.			Corrective		
					actionsaccomplished for tho		
	Findings include	»:			residents found to be affecte	d	
	_				by the alleged		
	Based on observ	ation with the			deficientpractice.		
		mager the Large Dining			The identified battery operate		
					emergencylight was replaced		
		arge had a battery			10/14/15 and is in proper work order.	ang	
		ncy light that was not lit			Identification of otherresiden	ite	
	at the time of ob	servation. Based on			having the potential to be		
	interview at the t	time of observation, the			affected by the same alleged		
	Maintenance Ma	nager explained the light			deficientpractice and		
		nd needs to be replaced.			corrective actions taken.		
					All other batteryoperated		
	3.1-19(b)				emergency lights were survey		
	3.1-19(0)				for proper operation. All found	to	
					bein proper working order.		
					Measures put in placeand		
					systemic changes made to		
					ensure the alleged deficient practice does notrecur.		
					The maintenance manager or		
					designee will conduct and		
					document therequired 30 second	ond	
					monthly and 90 minute annual		
					testing of all battery		
					operatedemergency lights.		
					How will the correctiveaction	1	
					be monitored to ensure the		
					deficient practice will not		
					recur?		
i l			I				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED		
		155530	B. WING		10/13/2015
			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	<u>t</u>	353 TY	LER ST	
SOUTH	SHORE HEALTH &	REHABILITATION CENTER		IN 46402	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				Results of auditswill be report to the monthly QAPI meeting. This will be on-going.	ed
K 0046	NFPA 101				
SS=F	LIFE SAFETY CO	DE STANDARD			
Bldg. 01	duration is provide	g of at least 1½ hour ed in accordance with 7.9.			
	19.2.9.1.		K 0046	This Plan of Correction	11/12/2015
		review and interview;	K 0040	constitutes my written allegation	
	1	d to ensure 7 of 7 battery		of compliance for the deficience	
		ncy lights in the facility		cited. However, submission of	
	was maintained	in accordance with LSC		this Plan of Correction is not a	l l
	7.9. LSC 7.9.3,	Periodic Testing of		admission that a deficiency ex	
	Emergency Ligh	ting Equipment, requires		or that one was cited correctly	
	a functional test	to be conducted for 30		This Plan of correction is	to
		y intervals and an annual		submitted to meet requirement established by state and feder	
		eted on every required		law. Corrective	ai
		* *		actionsaccomplished for tho	se
		emergency lighting		residents found to be affecte	l l
	_	ess than a 1 ½ hour		by the alleged	
		ment shall be fully		deficientpractice. On10/20/15	;
	operational for the	ne duration of the test.		the maintenance manager	
	Written records	of visual inspections and		conducted and documented a	l l
	tests shall be kep	ot by the owner for		second monthlyand an annual	
	_	e authority having		testing of 90 minutes for the	
		s deficient practice could		seven identified battery back- uplight fixtures. Measures put	in
	*	ts, staff and visitors		place andsystemic changes	""
				made to ensure the alleged	
	throughout the fa	aciity.		deficient practice does not	
				recur. Themaintenance manage	ger
	Findings include	:		was in-serviced on 10/20/15 b	
				the administrator regardingthe	
	Based on record	review with the		appropriate testing and	_
	Maintenance Ma	nager on 10/13/15 at		documentation requirements of	f
		ocumentation was		the identifiedbattery back-up	
	· ·	iew for an annual ninety		emergency lights. How will the correctiveaction be monitore	
		even battery operated		to ensure the deficient practi	l l
	Infinite test off se	von battery operated		to onsure the deficient practi	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R6Z921

Facility ID: 000369

If continuation sheet Page 11 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	01	COMPLI	
		155530	B. WI	NG		10/13/	2015
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER		353 TYLER ST GARY, IN 46402			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
TAG		s. Based on interview at		IAG	will not recur? The maintenar		DATE
	the time of recor			manager will monitor compliance			
		nager acknowledged the			and report findings atmonthly		
	aforementioned				QAPI meeting. This will be on-going,		
	W101 0111 011 011 0 11 0 11 0 11 0 11 0				on-going,		
	3.1-19(b)						
	, ,						
K 0050	NFPA 101						
K 0050 SS=F	LIFE SAFETY CO	DE STANDARD					
Bldg. 01		at unexpected times					
on each shif		ditions, at least quarterly					
		e staff is familiar with aware that drills are part					
	•	tine. Responsibility for					
		lucting drills is assigned					
		persons who are qualified ship. Where drills are					
		en 9 PM and 6 AM a coded					
		ay be used instead of					
		19.7.1.2	IZ O	050	This Plan of Correction		11/12/2015
		rd review and interview,	K 00	030	constitutes my written allegation	on	11/12/2015
	_	I to conduct fire drills			of compliance for the deficience		
	•	n shift for 1 of the last 4			cited. However, submission of this Plan of Correction is not a		
	•	s. This deficient practice			admission that a deficiency ex		
		taff and residents.			or that one was cited correctly This Plan of correction is		
	Findings include				submitted to meet requiremen		
		review of the "Fire Drill			established by state and feder law.	al	
	_	ith the Maintenance			Corrective		
	•	3/15 at 10:08 a.m., third			actionsaccomplished for tho		
		the fourth quarter of			residents found to be affecte	d	
		ailable for review. Based			by the alleged deficientpractice.		
		Maintenance Manager			The Maintenance Supervisor	is	
	acknowledged th	ne aforementioned			responsible forall fire drills		
	condition.				conducted in the facility. The f	ıre	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R6Z921

Facility ID: 000369

If continuation sheet Page 12 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
	155530	B. WING		10/13/2015	
		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	353 TYI			
SOUTH	SHORE HEALTH & REHABILITATION CENTER		IN 46402		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	BROWING BLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	3.1-19(b)		beenreviewed to ensure that a	II	
			fire drills are conducted at		
	2. Based on record review and interview,		unexpected times.		
			Identificationof other residen	ts	
	the facility failed to conduct quarterly fire		having the potential to be		
	drills at unexpected times for 4 of 4		affected by the same		
	quarters. This deficient practice affects		allegeddeficient practice and corrective actions taken.		
	all staff and residents.		No fire drills will be held within	. 2	
			hours ofeach other within the	12	
	Findings include:		same 12 month period.		
			Measures put in placeand		
	Based on record review of the "Fire Drill		systemic changes made to		
	Report" forms with the Maintenance		ensure the alleged deficient		
	•		practice does not recur.		
	Manager on 10/13/15 at 10:08 a.m., four		The Administrator and		
	sequential second shift fire drills took		Maintenance Manager willrevi	ew	
	place between 7:17 p.m. and 8:15 p.m.		the yearly fire drill schedule to		
	for four of the last four quarters. Based		ensure compliance. How will the correctiveaction		
	on interview at the time of record review,		be monitored to ensure the		
	the Maintenance Manager acknowledged		deficient practice will not		
	the aforementioned condition.		recur?		
			The Maintenance Manager w	II .	
	3.1-19(b)		report theschedule at the mon	thly	
	3.1-51(c)		QAPI meeting		
	3.1-31(c)				
K 0052	NFPA 101				
SS=E	LIFE SAFETY CODE STANDARD				
Bldg. 01	A fire alarm system required for life safety is				
	installed, tested, and maintained in				
	accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an				
	approved maintenance and testing program				
	complying with applicable requirements of				
	NFPA 70 and 72. 9.6.1.4				
	Based on record review and interview,	K 0052	This Plan of Correction	11/12/2015	
	the facility failed to ensure 1 of 12 smoke		constitutes my written allegation of compliance for the deficience	on	

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR I.SC IDENTIFYING INTORMATION) detectors was maintained in accordance with the applicable requirements of NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity trests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms show any increase over the previous year, calibration tests shall be performed. A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 (X5) PREFIX TAG COMPLETION 10/13/2015 STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 (X5) COMPLETION 10/13/2015 (X5) COMPLETION 10/13/2015 (X5) COMPLETION 10/13/2015 (X5) COMPLETION 10/13/2015 (X5) COMPLETION 10/14/16/1602 COMPLETION 10/13/2015 10/13/2015 10/13/2015 10/13/2015 10/13/2015 10/13/2015 10/13/2015 10/13/2015 10/13/2015 10/13/2016 10/13/2015 10/13/2015 10/13/2016 10/13/2015 10/13/2016 10/13/2015 10/13/2016 10/1	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG WITH THE PROPERTIAL PROPERTIAL REGULATORY OR LSC IDENTIFYING INFORMATION) detectors was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, Stational Fire Alarm Code. NFPA 72, Stational Fire Alarm Code. NFPA 72, Stational Fire Alarm Code. NFPA 73, Stational Fire Alarm Code. NFPA 74, National Fire Alarm Code. NFPA 75, Tag requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	<u> </u>			ETED	
SOUTH SHORE HEALTH & REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG With the applicable requirements of With the applicable requirements of Sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms show any increase over the previous year, calibration tests shall 353 TYLER ST GARY, IN 46402 ID PREVIXER ST GARY, IN 46402 ID PREVIXER ST GARY, IN 46402 ID PREVIXER ST GARY, IN 46402 (X5) COMPLETION DATE Cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. Corrective actionsaccomplished for those residents found to be affected by the alleged deficient practice. The facility will ensure that documentation is available to show testing of the smoke detectors throughout the facility. All smoke detectors have been inspected and are fully functional. Testing of the detectors was completed on 77/14/14. Please see supporting documentationitat indicates that the "Wing 4 small dining" smoke detector that failed wasreplaced.			155530	B. WING 10/13/2015			2015	
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nuisance alarms show any increase over the previous year, calibration tests shall documentationthat indicates that the "Wing 4 small dining" smoke detector that failed wasreplaced.		trends of these a	larms shall be					
the previous year, calibration tests shall the "Wing 4 small dining" smoke detector that failed wasreplaced.		maintained. In z	zones or in areas where			7/14/14. Please see supporting	g	
the previous year, calibration tests shall the previous year, calibration tests shall detector that failed wasreplaced.		nuisance alarms	show any increase over					
detector triat failed wasreplaced.			-			_		
Identification of other residents			, canoration tests shari			· ·		
		_	mala dataatan is with in				its	
To ensure each smoke detector is within its listed and marked sensitivity range it having the potential to be affected by the same alleged								
to listed the market sensitivity range, it						, ,		
shall be tested using any of the following corrective actions taken.		shall be tested us	sing any of the following			•		
methods: No other areas affected.		methods:						
(1) Calibrated test method Measures put in placeand		(1) Calibrated te	st method					
(2) Manufacturer's calibrated sensitivity systemic changes made to		(2) Manufacture	r's calibrated sensitivity					
test instrument ensure the alleged deficient		` ′	<u>, </u>					
(3) Listed control equipment arranged for practice does notrecur.			ol equipment arranged for			practice does notrecur.		
Administrator in-serviced the		` ′	of application arranged for					
the purpose Maintenance Manager on the			4/414					
(4) Smoke detector/control unit importance offollowing up in a		` '						
arrangement whereby the detector causes timely manner regarding all		1	-					
a signal at the control unit where its testing documentation including fire alarm, sprinkler, and		a signal at the co	ontrol unit where its				and	
sensitivity is outside its listed sensitivity smoke detector sensitivity.		sensitivity is out	side its listed sensitivity				ai iu	

PRINTED: 11/09/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/13/2015
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE
	methods approve having jurisdiction. Detectors found outside the listed range shall be clobe replaced. This affect staff and a Findings include. Based on record Maintenance Ma 10:18 a.m., the redocumentation of sensitivity test w 07/24/14 by Religindicated that "V smoke detector from interview at the first the Maintenance the aforemention."	to have a sensitivity I and marked sensitivity eaned and recalibrated or as deficient practice could at least 35 residents. review with the mager on 10/13/15 at most recent if a smoke detector has completed on hable Fire and Security Ving 4 small dining" Failed. Based on an hatime of record review, Manager acknowledged hed condition and was he documentation for		How will the correctiveact be monitored to ensure the deficient practice will not recur? MaintenanceManager will in the Administrator of all Fire sprinkler, and smokesensititest schedules and results.	e inform alarm,
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CO Required automat	DE STANDARD ic sprinkler systems are			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 COMPLETED 155530 B. WING 10/13/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 353 TYLER ST SOUTH SHORE HEALTH & REHABILITATION CENTER **GARY. IN 46402** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 K 0062 This Plan of Correction 11/12/2015 1. Based on observation and interview, constitutes my written allegation the facility failed to ensure 1 of 1 of compliance for the deficiencies sprinkler systems was continuously cited. However, submission of maintained in reliable operating this Plan of Correction is not an admission that a deficiency exists condition. This deficient practice could or that one was cited correctly. affect staff only. This Plan of correction is submitted to meet requirements Findings include: established by state and federal law. Corrective Based on observations with the actionsaccomplished for those Maintenance Manager on 10/13/15 at residents found to be affected 11:03 a.m. then again at 1:20 p.m., 22 out by the alleged. of 26 ceiling tiles were missing in Room 1. The ceiling tiles that were missing in Storage Room 405 405 being used as storage. Then again 14 have been replaced on 10/16/15. out of 20 ceiling tiles were missing in the TheCeiling tiles that were missing Mechanical Room. Based on interview at in the mechanical room have the time of observation, the Maintenance been replaced on 10/16/15. Manager acknowledged the 2.The boxes that were 6inches away from the sprinkler head in aforementioned condition. the freezer have been removed 10/14/15.Also, the ice that was 3.1-19(b) built up on the sprinkler head has been removed10/14/15. 3. The indicated five 2. Based on observation and interview, missingescutcheons will be the facility failed to ensure the spray replaced by 11/10/15. pattern for 1 of 1 sprinkler head in the Identification of otherresidents Kitchen Freezer. NFPA 25, 1998 Edition having the potential to be affected by the same alleged Standard for the Inspection, Testing, and deficientpractice and Maintenance of Water-Based Fire corrective actions taken Protection Systems, Section 2-2.1.2 states deficient practice.

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unacceptable obstructions to spray

patterns shall be corrected. NFPA 13,

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1.An inventory of thefacility for

missing ceiling tiles was

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CENTERS FOR MEDICARE & MEDICAID SERVICES X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 COMPLETED 155530 B. WING 10/13/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 353 TYLER ST SOUTH SHORE HEALTH & REHABILITATION CENTER **GARY. IN 46402** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG conducted with no findings. 1999 Edition Standard for the Installation 2.An inventory of the facility for of Sprinkler Systems, Section 5-8.5.1.1 missing escutcheonswas states sprinklers shall be located so as to conducted with no findings. minimize obstructions to discharge as Measuresput in place and defined in 5-8.5.2 and 5-8.5.3, or systemic changes made to ensure the alleged deficient additional sprinklers shall be provided to practicedoes not recur. ensure adequate coverage of the hazard. 1.The Administrator in-serviced This deficient practice affects staff only. the maintenancemanager on the need to have all ceiling tiles and Findings include: sprinkler head escutcheons inplace. Maintenance Manager will audit weekly rounds for Based on observation with the missing ceiling tiles. Maintenance Manager on 10/13/15 at 2. The Maintenance Manager 12:36 p.m., the Kitchen Freezer sprinkler in-serviced the dietarydepartment on the need to have at least an head was six inches away from boxes 18" clearance from each stored near it. Additionally, the sprinkler sprinklerhead. This action should head had built up ice on the sprinkler also stop ice build- up on the sprinkler head. Dietarymanager head deflector. Based on interview at the will audit freezer weekly for time of observation, the Maintenance compliance. Manager acknowledged the How will the corrective action aforementioned conditions. be monitored to ensure the deficient practice will not recur? 3.1-19(b) Resultsof weekly audits will be reported at QAPI monthly 3. Based on observation and interview, meetings or until problem the facility failed to ensure sprinkler isconsidered resolved. Problem will be considered resolved when heads in the facility were maintained. no newissues are identified over This deficient practice could affect staff a two month period. and up to 19 residents. Findings include:

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Based on observations the Maintenance Manager on 10/13/15 between 1:29 p.m.

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/13/2015
	ROVIDER OR SUPPLIER SHORE HEALTH &	REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE 'LER ST IN 46402	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	heads were missing a. 1 of 1 sprinkles Nurse's Station Mb. 1 of 3 sprinkles Nurse's Station St	er head in 500 Hall Medication Room er heads at the 500 Hall Shower Room er heads in the MDS er heads near RR 414 er heads in the Soiled ear the 500 Hall ew, The Maintenance wledged each missing			
K 0064 SS=E Bldg. 01	health care occupied. 9.7.4.1. 19.3.5.6 Based on observe facility failed to extinguishers reconstructed to the approcedures every NFPA 10, Standa Extinguishers Chi	guishers are provided in all ancies in accordance with 5, NFPA 10 ation and interview, the ensure 6 of 15 fire quiring a 12-year	K 0064	This Plan of Correction constitutes my written allegati of compliance for the deficien cited. However, submission of this Plan of Correction is not a admission that a deficiency experience or that one was cited correctly. This Plan of correction is submitted to meet requirement established by state and federlaw. Corrective	cies f an xists /.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u> COMPLETED			COMPLETED	
		155530	B. WING 10/13/2015			10/13/2015
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R			LER ST	
SOUTH	SHODE HEVI TH &	REHABILITATION CENTER			IN 46402	
					111 40402	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					actionsaccomplished for tho	
	Findings include	2:			residents found to be affecte	d
					by the alleged	
	Based on observ	vation on 10/13/15 from			deficientpractice. All 6 cited Fire extinguisherswi	:11
		00 p.m., the following			be replaced by 11/12/15.	¹¹¹
	was discovered:	-			Identification of otherresiden	nts
					having the potential to be	
	·	guisher near the Time			affected by the same alleged	
		Hall last six year test			deficientpractice and	
	was in 2008.				corrective actions taken.	
	b) the fire extinguisher in the Large				The Maintenance Manager	
	Dining Room la	st six year test was in			completed anaudit of all facility	
	2007.				fire extinguishers checking for	•
		guisher in the Unit 2 East			required 12 yearhydrostatic te	st.
	·	ast six year test was in			All in compliance.	
		ast six year test was iii			Measures put in place	
	2007.				andsystemic changes made	to
	· ·	guisher next to Kitchen			ensure the alleged deficient	
	Storage last six	year test was in 2007.			practice does not recur.	
	e) the fire exting	guisher in Kitchen			Audits for the facility	
	Storage last six	year test was in 2008.			fireextinguishers checking for	the
	f) the fire exting	uisher near resident room			required 12 hydrostatic test wi	Il be
		test was in 2007.			completedmonthly.	
	_	iew at the time of each			How will the correctiveaction	1
					be monitored to ensure the	
		Maintenance Manager			deficient practice will not	
	_	ach aforementioned			recur?	
	condition.				Results ofmonthly audits will b reported at QAPI monthly	e
					meetings or until problem	
	3.1-19(b)				isconsidered resolved. Proble	em
					will be considered resolved wh	nen
					no new issuesare identified ov	er er
					a three month period.	
K 0066	NFPA 101					
SS=B	LIFE SAFETY CO	=				
Bldg. 01		ons are adopted and				
	include no less th	an the following provisions:				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155530	B. W	NG		10/13/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8		353 TYL			
SOUTH	SHORE HEALTH &	REHABILITATION CENTER			IN 46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	or compartment we combustible gases stored and in any and such area is properties in the supervision. (2) Smoking by paresponsible is prodirect supervision. (3) Ashtrays of no safe design are promoting is permitted. (4) Metal contained devices into which are readily availables smoking is permitted. Based on observing facility failed to smoking was perresidents were montainer with a used for an ashtropractice could after residents who sing the supervision. Findings included as a second and the supervision of the supervision of the supervision.	atients classified as not hibited, except when under incombustible material and rovided in all areas where sted. The sers with self-closing cover in ashtrays can be emptied be to all areas where sted. The sers with self-closing cover in ashtrays can be emptied be to all areas where sted. The sers with self-closing cover in ashtrays can be emptied be to all areas where sted. The sers with self-closing cover was ray. This deficient effect staff and at least 25 moke cigarettes.	K 0	066	This Plan of Correction constitutes my written allegation of compliance for the deficience cited. However, submission of this Plan of Correction is not an admission that a deficiency export that one was cited correctly. This Plan of correction is submitted to meet requirement established by state and feder law. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Cigarette butts were cleaned upon the total proper and the resident smoking area and the resident smoking area on 10/14/15 and staff re-education smoking policy and proper	cies n ists ts al	11/12/2015

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/13/2015
	PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0070	cigarette butts on the ground. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned conditions. 3.1-19(b)		disposal of cigarettebutts in appropriate metal containers of 10/30/15. Identification of otherresider having the potential to be affected by the same alleged deficientpractice and corrective actions taken. Reviewed otherpotential areas cigarette butts and these area had no findings. What measures will beput in place or what systematic changes you will make to ensure deficientpractice does not recur? Housekeeping staff willmonite both staff and resident smokin areas for inappropriate discardedcigarette butts daily will clean up immediately. Disciplinary action willresult for any employee not following the proper disposal of cigarette butted deficient practice will not recur? Housekeeping staff willdaily monitor staff and resident smoking areas for inappropriate disposition ofcigarette butts. Housekeeping supervisor will report finding at the monthly QAPImeeting.	nts I Is for s I I I I I I I I I I I I I I I I I I I
K 0070 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such			

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	NT OF DEFICIENCIES X1) PROVIDER/SUPP OF CORRECTION IDENTIFICATION NU	î ´	MULTIPLE CC BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN		155530 B. W		01	10/13/2015
	195950	Б.			10/13/2015
NAME OF 1	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
SOLITH.	SHORE HEALTH & REHABILITATIOI	N CENTED	353 TYI	LER ST IN 46402	
				111 40402	
(X4) ID	SUMMARY STATEMENT OF DEFIC		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECED		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	
TAG	REGULATORY OR LSC IDENTIFYING IN devices do not exceed 212 degrees		IAG	DEFICIENCE)	DATE
	degrees C) 19.7.8	F. (100			
	Based on observation, interview,	and K	0070	This Plan of Correction	11/12/2015
	record review, the facility failed		0070	constitutes my written allegation	on
	enforce the policy for the use of			of compliance for the deficience	
	portable space heaters in accorda			cited. However, submission of	
	1 -	nce with		this Plan of Correction is not a admission that a deficiency ex	l l
	NFPA 101, Section 19.7.8. This	CC1		or that one was cited correctly	
	deficient practice could affect sta	ff only.		This Plan of correction is	
				submitted to meet requirement	
	Findings include:			established by state and feder	al
				law.	
	Based on record review with the			What corrective actionswill b	e
	Maintenance Manager on 10/13/2	15		accomplished for those residents found to have been	
	between 9:29 a.m. and 10:50 a.m	., the		affected by thedeficient	
	space heater policy states the faci	ility does		practice?	
	not allow space heaters. Based o	n		The space heater locatedin the	e
	observation at 1:42 p.m., a space			DON's office was removed	
	was discovered in the Director of			immediately by the maintenan	
	office. Based on interview at the	•		manager. Management Staff of in serviced on not usingspace	was
	observation, the Maintenance Ma			heaters in the facility on 10/15	/15.
	acknowledged the aforementione	•		How will you identifyother	
	condition and that space heaters v			residents having the potentia	ıl
	_	were a		to be affected by the same	
	violation of the facility's policy.			deficientpractice and what	
	21.10(1)			corrective action will be take	n?
	3.1-19(b)			All other offices infacility were inspected for space heaters ar	,
				there were no findings.	'
				Whatmeasures will be put int	:o
				place or what systematic	
				changes you will make to	
				ensuredeficient practice does	S
		1		not recur?	
				Any further infractionsin the us of portable space heaters will	se
				result in disciplinary action.	
				Housekeeping will monitor du	ring
				office cleaningschedule to ens	~

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		A. BUILDING B. WING	<u>01</u>	COMPLETED 10/13/2015	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE 'LER ST IN 46402	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0075 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CO Soiled linen or trado not exceed 32 The average dens a room or space of (20.4 L/sq m). A c is not exceeded w m) area. Mobile s collection receptate than 32 gal (121 L protected as a haz attended. 19.7. Based on observ facility failed to gallons for soiled receptacles was a 64 square foot an protected as a haz areas with hazare	DE STANDARD sh collection receptacles gal (121 L) in capacity. ity of container capacity in loes not exceed .5 gal/sq ft capacity of 32 gal (121 L) ithin any 64 sq ft (5.9-sq oiled linen or trash cles with capacities greater .) are located in a room cardous area when not 5.5 ation and interview, the ensure a capacity of 32 d linen or trash collection not exceeded within any rea which was not zardous area for 3 of 3 dous storage. This e could affect staff and is.	K 0075	no portable space heaters are being used. How will the correctiveaction be monitored to ensure the deficient practice will not recur? Housekeeping supervisorwill monitor office cleaning scheduland results will be reported to monthly QAPImeeting. This will be on-going. This Plan of Correction constitutes my written allegation of compliance for the deficient cited. However, submission of this Plan of Correction is not a admission that a deficiency export that one was cited correctly. This Plan of correction is submitted to meet requirement established by state and feder law. Corrective actions accomplishedfor those residents found to be affected by the alleged deficient practice.	alle iill 11/12/2015 on cies in cists its ral
	Maintenance Ma	nager on 10/13/15		The 6 indicated 40gallon	

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	OF CORRECTION IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 10/13/2015
	PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	between 11:00 a.m. and 1:40 p.m., the following was discovered: a) One forty gallon container storing diapers in the corridor near resident room 407 b) One forty gallon container storing diapers in the corridor near resident room 405 c) Two separate forty gallon containers storing trash in the Large Dining Room d) Two separate forty gallon containers storing soiled linen and one forty gallon container storing trash in the corridor next to the 500 Hall nurse's station. Based on an interview at the time of each observation, the Maintenance Manager acknowledged each of the aforementioned conditions. 3.1-19(b)		containers were replaced with gallon containers on 10/22/15 Identification of otherresider having the potential to be affected by the same alleged deficientpractice and corrective actions taken. All residents had thepotential be affected, however there wano actual harm to any. Measures put in placeand systemic changes made to ensure the alleged deficient practice does notrecur On 10 /22/2015 the Laundry/Housekeeping/Nursir epartments were re-educated the use of the new 32 gallon containers. The housekeepingsupervisor designee will inspect for compliance weekly. How will the correctiveaction be monitored to ensure the deficient practice will not recur? Resultsof weekly audits will be reported at QAPI monthly or uproblem isconsidered resolved resolved when no newissues identified over a two month period.	entis agD on or entil d.
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier.	K 0130	This Plan of Correction constitutes my written allegation of compliance for the deficience cited. However, submission of	cies

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLETED
		155530	B. W	ING		10/13/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8		353 TYI		
SOUTH SHORE HEALTH & REHABILITATION CENTER				IN 46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		IAU	this Plan of Correction is not a	
		quires all health care			admission that a deficiency ex	
		naintained and operated to			or that one was cited correctly	
	minimize the po	•			This Plan of correction is	
	emergency requi	iring the evacuation of			submitted to meet requiremen	ts
	the occupants. L	SC 8.2.3.2.4.2 requires			established by state and feder	al
	pipes, conduits,	bus ducts, cables, wires,			law Corrective	
		atic tubes and ducts, and			actionsaccomplished for tho	
		service equipment that			residents found to be affecte	a
	_	e barriers shall be			by the alleged deficient practice.	
	protected as follo				All penetrations noted will be	
					sealed with 3M Fire Barrier 4H	Ir
		tween the penetrating			rated system by 11/12/15.	
		barrier shall meet one of			2. Identification ofother	
	the following co				residents having the potentia	al
		ed with a material that is			to be affected by the same	
	capable of main	taining the fire resistance			allegeddeficient practice and	
	of the fire barrie	r.			corrective actions taken.	
	b. It shall be pro	tected by an approved			All remaining smokebarriers w inspected for un-sealed	ere
	_	signed for the specific			penetrations. No findings.	
	purpose.				3. Measures put inplace and	
		enetrating item uses a			systemic changes made to	
		ate the fire barrier, the			ensure the alleged deficient	
	_				practice doesnot recur.	
		olidly set in the fire			Any new construction or repair	irs
	1	space between the item			involving wires or pipes	-ld
		nall meet on of the			penetratingfirewalls will be sea with 3M Fire Barrier 4Hr rated	ileu
	following condit				system.	
	a. It shall be fille	ed with a material that is			4. How will thecorrective	
	capable of maint	taining the fire resistance			action be monitored to ensur	·e
	of the fire barrie	r.			the deficient practice will not	
	b. It shall be pro	tected by an approved			recur?	
	_	signed for the specific			Any new construction orrepail	rs
	purpose.	- 6			involving wires or pipes	
		ractice could affect staff			penetrating firewalls will be	
	_				inspected by theMaintenance Manager, or designee, for	
		using the Large Dining			appropriate fire barrier	
	Room.					

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PRINTED: 11/09/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/13/2015
	PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Findings include:		applicationprior to completion project.	of
K 0147 SS=E Bldg. 01	Based on an observation with the Maintenance Manager on 10/13/15 at 2:14 p.m., the fire barrier wall near the Kitchen above the ceiling tile had an unsealed penetration measuring one inch around conduit, a four inch by 6 inch penetration about conduit, a five inch by five inch gap around wires, and a 14 inch by 8 inch brick was removed. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned conditions and provided the measurements. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 multiplugs and 7 of 7 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient	K 0147	This Plan of Correction constitutes my written allegation of compliance for the deficient cited. However, submission of this Plan of Correction is not a admission that a deficiency exor that one was cited correctly. This Plan of correction is submitted to meet requirement established by state and feder law. Corrective actionsaccomplished for tho residents found to be affected.	n ists . ts al

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		01	COMPLETED			
		155530	B. WING			10/13/2015			
		l .	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	I			
NAME OF P	PROVIDER OR SUPPLIER	t		1					
SOUTH SHORE HEALTH & REHABILITATION CENTER				353 TYLER ST GARY, IN 46402					
					11 10702				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APP		PRIATE			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		1	1110			DATE		
	practice affects staff and up to 37				by the alleged deficientpractice.				
	residents.				1.) All indicated extension				
	Findings include:			cordsand surge protectors		be			
					removed by 11/12/15.				
					All indicated missing outle	t			
	Based on observation with Maintenance			covers wereinstalled on 10/16/15.					
	Manager on 10/13/15 between 11:13 a.m.								
					Measures put in placeand				
	to 1:46 p.m. the following was			systemic changes made to					
	discovered:				ensure the alleged deficient				
	a) a surge protector powering a				practice does notrecur.				
	refrigerator in the Dietary Office.				1.Management staff was in-serviced on how				
	b) a multiplug powering the time clock in				extensioncords are not to be u	_{ised}			
	300 Hall			in the facility. This was completed					
	c) an extension cord powering a				on 10/19/15.				
	refrigerator in the Activities Office.				2.A survey of the facility				
	d) an extension cord powering a radio				confirming that allelectrical ou	tlets			
	· ·	-			had covers. No other issues.				
	and microwave, additionally a surge protector was powering a microwave		How will the correctiveacti			ו			
					be monitored to ensure the deficient practice will not				
	refrigerator in the Maintenance Room. e) a surge protector powering a				reoccur?				
					The maintenancesupervisor or				
	refrigerator in the 400 Hall Medication				his designee will conduct wee				
	Room.				rounds to ensure that				
	f) an extension cord powering a copier in the Electrical Closet g) a multiplug powering two refrigerators				extensioncords are not being				
					used for anything other than for	or			
					temporary use.				
	in the 500 Hall Nurse's Station				How will the correctiveaction				
	Medication Room.				be monitored to ensure the deficient practice will not				
	h) a surge protector powering a				recur?				
					The results of this review will	_{be}			
	refrigerator in resident room 501				presentedat the monthly QAP				
	Based on interview at the time of				meeting. Monitoring will be				
	observation, the Maintenance Manager				on-going.				
	acknowledged ea	ach aforementioned							
condition.									

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING B. WING		<u>01</u>	COMPLETED 10/13/2015		
155530			B. W			10/13/	2015	
NAME OF P	PROVIDER OR SUPPLIER	<u>.</u>			ADDRESS, CITY, STATE, ZIP CODE			
SOUTH SHORE HEALTH & REHABILITATION CENTER				353 TYLER ST GARY, IN 46402				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCE		DATE	
	3.1-19(b)	3.1-19(b)						
	2. Based on observation and interview,							
	the facility failed to maintain an electrical							
	outlet in 1 of 53 resident rooms, 1 of 1							
	Therapy rooms, and 1 of 1 400 Halls.							
	NFPA 70, National Electrical Code 70,							
	1999 edition, Article 410-3, Live Parts,							
	requires receptacles to have no live parts							
	normally exposed to contact. This							
	_	e affects staff and 25						
	residents.							
	Findings include:							
	Based on observations with the							
	Maintenance Manager on 10/13/15							
	between 11:33 a.m. and 12:59 p.m., the							
	following was discovered:							
	a) a missing outlet cover behind the multiplug adapter for the time clock in the 300 Hall b) a missing outlet cover in East Wing							
	Therapy							
	c) a missing outlet cover in resident room 312 Based on interview at the time of each							
	observation, the Maintenance Manager							
	acknowledged each aforementioned							
	condition.							
	-							
	3.1-19(b)							

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